

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.  
30169

1. PLACE OF DEATH  
County Linn Registration District No. 312  
Township Barren Primary Registration District No. 231  
City (No. ....) St. .... Ward .....

2. FULL NAME Not Named  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Boy 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) .....

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF .....

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 8-31-28

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
11

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Owensville Mo R 3

10. NAME OF FATHER Nesley Norman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) ✓

12. MAIDEN NAME OF MOTHER Lula Ellis Halliday

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Oak Hill Mo.

14. INFORMANT Nesley Norman  
(Address) Owensville Mo

15. FILED 9-13-28 W. F. Gettrustro  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-11 1928

17. I HEREBY CERTIFY, That I attended deceased from 9-9 1928, to 9-11 1928, that I last saw h. live alive on 9-9 1928, and that death occurred, on the date stated above, at 8:30 a.m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Cholera Infantum

W. F. Gettrustro (Signature)  
CONTRIBUTORY (SECONDARY) .....

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....  
DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
WAS THERE AN AUTOPSY?.....  
WHAT TEST CONFIRMED DIAGNOSIS.....  
(Signed) Edwin Mellis M. D.  
Owensville Mo. (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Liberty cemetery DATE OF BURIAL 9-11-1928  
20. UNDERTAKER W. F. Gettrustro ADDRESS Owensville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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SECRET

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Gasconade Registration District No. 382 File No. ....  
Township ..... Primary Registration District No. 6231 Registered No. ....  
City ..... (No. ....) St. .... Ward)

**2. FULL NAME**

Ingrid Normann  
(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(Use the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work ..... (duration) yrs. mos. ds.  
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) yrs. mos. ds.  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED Sept 15 1928 Ed Bunge REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-11-28

17. I HEREBY CERTIFY That I attended deceased from ..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred, on the date stated above, at ..... m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

CONTRIBUTORY (SECONDARY) ..... (duration) yrs. mos. ds.  
..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.  
, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state at of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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